THE MARYLAND MEDICAL ASSISTANCE PROGRAM

EPSDT Chiropractic
EPSDT Speech Language Pathology
EPSDT Occupational Therapy

Physical Therapy

PROVIDER MANUAL

For Medicaid Provider Types 13, 16,17,18 and 28*

This manual is provided as a tool to assist in understanding Maryland Medicaid's coverage of these services and is to be used as a guide only. As a provider, it is your responsibility to adhere to established Program policies and regulations for these services.

*13 = MD MA enrolled chiropractor
16 = MD MA enrolled physical therapist
17 = MD MA enrolled speech language pathologist
18 = MD MA enrolled occupational therapist
28 = MD MA enrolled therapy group

July, 2010

MARYLAND MEDICAL ASSISTANCE PROGRAM

PROVIDER MANUAL FOR EPSDT CHIROPRACTIC, SPEECH LANGUAGE PATHOLOGY AND OCCUPATIONAL THERAPY PHYSICAL THERAPY

For Medicaid Provider Types 13, 16,17,18 and 28

TABLE OF CONTENTS

PhysicalTherapyServices (COMAR 10.09.17)
EPSDT Chiropractic Services (COMAR 10.09.37)
EPSDT Occupational Therapy Services (COMAR 10.09.37)
EPSDT Speech Language Pathology Services (COMAR 10.09.37)
(For Medicaid Provider Types 13, 16,17,18 and 28)

Effective November 1, 1999, Occupational Therapy, Speech Language Pathology and Physical Therapy services were "carved-out" from the HealthChoice Managed Care Organization (MCO) benefits package for recipients who are 20 years of age and younger. (This does not include home health and inpatient services.) The services for this Medicaid population are now considered "fee-for-service" and are billed directly to the Medicaid Program. [Note: All codes billed by pediatricians, internists, family practitioners, general practitioners, nurse practitioners, and neurologists or other physicians to determine whether a child has a need for Occupational Therapy, Physical Therapy or Speech Therapy services remain the responsibility of the MCO and may not be billed fee-for-service.] The MCOs continue to be responsible for therapy services rendered to recipients who are 21 years of age and older, EPSDT: chiropractic care, inpatient and home health services. Please contact the MCO for these services.

For the most part, the Occupational and Speech Therapy services addressed in this manual are limited to Maryland Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) population (recipients who are 20 years of age and younger). An exception to this age limitation is physical therapy services. [It is also worth noting again that all EPSDT chiropractic services, therapy services for recipients who are 21 years of age or older, inpatient and home health services remain under the MCO coverage of benefits. Contact the MCO for their billing policy/procedure.] . Following is a chart outlining the payer for these services:

Service	Bill the MCO	Bill Fee for Service (FFS) Medicaid
Occupational Therapy	21 + older	0 - 20
Physical Therapy	21 + older	0 - 20
Speech Language	21 + older	0 - 20
Chiropractic	0-20	----
Home Health Therapy	0-99	-----
Inpatient Therapy	0-99	-----
DME/DMS	0-99	

Therapy services provided by a hospital, home health agency, inpatient facility, nursing home, RTC, local lead agency, school or in accordance with an IEP/IFSP, model waiver etc. are not specifically addressed in this manual.

If you have questions regarding therapy services provided by provider types that are not addressed in these guidelines, contact the appropriate Medicaid office listed below:

Toll free number for Medicaid Divisions 1-877-463-3464
(ask for extension 7 + last 4 digits of the number listed below)

	extension
• Hospital Services (COMAR 10.09.06)	(410) 767- 1722
• Nursing Facility Services (COMAR 10.09.10)	(410) 767- 1444
• Residential Treatment Center Services (COMAR 10.09.29)	(410) 767- 1478
• Clinic Services(COMAR 10.09.08)	(410) 767 - 5706

Division of Waiver Programs (410) 767- 5220

- Community Based Services for Developmentally Disabled Individuals Pursuant to a 1915© Waiver (COMAR 10.09.26)
- Home Care for Disabled Children Under a Model Waiver (COMAR10.09.27)
- Home/Community Based Services Waiver for Older Adults (COMAR10.09.54)
- Home and Community Based Services Waiver for Adults with Physical Disabilities (COMAR 10.09.55)
- Home and Community Based Services Waiver for Children with Autism Spectrum Disorder (COMAR 10.09.56)

Division of Community Long Term Care Services (410) 767- 1444

- Medical Day Care Services (COMAR 10.09.07)

Division of Nursing Services (410) 767- 1448

- Home Health Services (COMAR 10.09.04)
- Hospice Care (COMAR 10.09.35)
- EPSDT: Private Duty Nursing (COMAR 10.09.53)
- REM Program (COMAR 10.09.69)

Division of Children's Services (410) 767- 1903

- EPSDT: School Health Related Services and Health Related Early Intervention Services [IEP/IFSP Services] (COMAR 10.09.50)

(Medicaid Provider Types 13, 16,17,18 and 28)

EPSDT Occupational Therapy, EPSDT Speech Language Pathology and EPSDT Chiropractic services are covered when the services are: [limited to recipients who are 20 years of age or younger.]

- necessary to correct or ameliorate defects and physical illnesses and conditions discovered in the course of an EPSDT screen
- provided upon the referral order of a screening provider
- rendered in accordance with accepted professional standards and when the condition of a participant requires the judgement, knowledge, and skills of a licensed occupational therapist, licensed speech pathologist or licensed chiropractor
- delivered in accordance with the plan of treatment developed at the time of initial referral
- limited to one initial evaluation per condition
- delivered by a licensed chiropractor, licensed occupational therapist, or a licensed speech pathologist

[NOTE: chiropractic services are covered through the MCO - contact the MCO for preauthorization information if an MCO enrollee]

In order to participate as an EPSDT-referred services provider, the provider shall:

- gain approval by the screening provider every six (6) months or as authorized by the Department for continued treatment of a participant. Approval must be documented by the screening provider and the therapist or chiropractor in the recipient's medical record
- have experience with rendering services to individuals from birth through 20 years of age
- submit a quarterly progress report to the recipient's primary care provider.
- maintain medical documentation for each visit

The following therapy services are <u>not covered</u>:

- services provided in a facility or by a group where reimbursement is covered by another segment of the Medicaid Program

PHYSICAL THERAPY [no age limitation]

Medically necessary physical therapy services ordered in writing by a physician, dentist or podiatrist when the services are:

- provided by a licensed physical therapist or by a physical therapist assistant under direct supervision by the licensed physical therapist
- provided in the provider's office, the recipient's home, or a domiciliary level facility
- diagnostic, rehabilitative, therapeutic and directly related to the written treatment order
- of sufficient complexity and sophistication, or the condition of the patient is such, that the services of a physical therapist are required
- rendered pursuant to a written treatment order that is signed and dated by the prescriber and which the order specifies: 1) part or parts to be treated; 2) type of modalities or treatments to be rendered; 3) expected results of physical therapy treatments; 4) frequency and duration of treatment
- treatment order is kept on file by the therapist as part of the recipient's permanent record
- not altered in type, amount, frequency, or duration by the therapist unless medically indicated. The physical therapist shall make necessary changes and sign the treatment order, advising the prescriber of the change and noting it in the patient's record
- limited to one initial evaluation per condition
- if pursuant to a written treatment order for treatment exceeding 30 days, reviewed monthly, thereafter, by the prescriber in communication with the therapist and the order is either rewritten or a copy of the original order is initialed and dated by the prescriber. A quarterly progress report should be submitted to the recipient's primary care physician.

Services are to be recorded in the patient's permanent record which shall include:

- the treatment order of the prescriber
- the initial evaluation by the therapist and significant past history
- all pertinent diagnoses and prognoses
- contraindications, if any and
- progress notes, at least once every two weeks

The following physical therapy services are <u>not covered</u>:

- services provided in a facility or by a group where reimbursement for physical therapy is covered by another segment of the Medicaid Program.
- services performed by licensed physical therapy assistants when not under the direct supervision of a licensed physical therapist
- services performed by physical therapy aides
- more than one initial evaluation per condition

Preauthorization

Contact the MCO for information regarding their billing and preauthorization procedures for chiropractic services, therapy services for recipients who are 21 or older, home health and inpatient services.

Preauthorization is not required under the fee-for-service system; however, it is expected that a quarterly care plan be shared with the primary care provider. Please review the procedure code and fee schedule for further information regarding code 97139.

Provider Enrollment:

PLEASE NOTE: UNDER THE MARYLAND MEDICAID PROGRAM, THERAPISTS AND CHIROPRACTORS WHO ARE PART OF A PHYSICIAN'S GROUP ARE NOT CONSIDERED PHYSICIAN EXTENDERS. SERVICES RENDERED BY THESE PROVIDERS CANNOT BE BILLED UNDER THE SUPERVISING PHYSICIAN'S RENDERING NUMBER. THESE PROVIDERS MUST COMPLETE AN ENROLLMENT APPLICATION AND BE ASSIGNED A MARYLAND MEDICAID PROVIDER NUMBER THAT HAS BEEN SPECIFICALLY ASSIGNED TO THEM UNDER THEIR NAME. THE NUMBER WILL BE USED WHEN BILLING DIRECTLY TO MEDICAID.

Therapists and chiropractors ***must be*** licensed to practice their specialties in the jurisdictions where they practice. (Chiropractors must be licensed and enrolled as a physical therapist in order to bill for physical therapy services.)The addresses and telephone numbers of Maryland's state licensing boards are listed for you at the end of this document. Verification of licensure status with the appropriate State Board is conducted for all applicants during the enrollment application review. Copies of licenses are required for all out of state applicants. License numbers are required for all Maryland applicants.

On your application, numerical 2 and 3 digit codes (explained in your provider application form) identify your provider type and specialty to the Maryland Medicaid billing system as an authorized provider for prescribed therapy services. On your application, you will indicate whether you are a group practice, individual practice or a rendering provider within a group. (At this time, provider type 28, Therapy Group, will enroll as a practice type of 99 - other.)

Provider Type	Type of Practice	Specialty
18- Occupational Therapist	35 (group) or 30 (individual or renderer in a group)	EPSDT –Occupational Therapy (173)
17- Speech Language Pathologist	35 (group) or 30 (individual or renderer in a group practice)	EPSDT – Speech /Language Pathology (209)
13- Chiropractor	35(group) or 30(individual or renderer in a group practice)	EPSDT – Chiropractor (106)
16- Physical Therapist	35(group) or 30 (individual or renderer in a group practice)	Physical Therapy (189)
28- Therapy Group	99(other)	Must comprise of at least two

		different specialties: OT (173), PT (189), SP (209)

(Medicaid Provider Types 13, 16,17,18 and 28)

Provider Enrollment (continued):

After a Maryland Medical Assistance Program provider application has been approved, the Program will enroll the provider and issue a 9 digit provider identification number. This number will permit the provider to bill the Program's computerized payment processing system for services that are covered under the fee-for-service system. Applicants enrolling as a renderer in a group practice must be associated with a Maryland Medicaid existing or new group practice of the same provider type [i.e. a PT can enroll as a renderer in a PT group practice but not in a physician group practice]

Please note: At this time, renderers in a therapy group provider type practice [type 28] are not required to be assigned an individual rendering provider number. A listing of therapists and license numbers of participating members of the practice must be attached to the therapy group [type 28] application for in-state applicants. Out of state applicants must submit a copy of all licenses and/or certificates of the therapists participating in the practice. Changes to the practice must be brought to the attention of the Program.

PATIENT ELIGIBILITY: (Recipient must be Medicaid eligible on the date of service. (Utilize the Program's EVS system to verify eligibility.)

21years of age and older

The majority of Maryland Medicaid recipients are enrolled in an MCO. It is customary for the MCO to refer their enrollees to therapists in their own provider network for this particular age population . If a recipient is 21 or older and is enrolled in an MCO, preauthorization may be required by the MCO before treating the patient. Contact the MCO for preauthorization/treatment procedures.

Under Medicaid's fee-for-service system, coverage for therapy services for the 21and over age population is limited to physical therapy services unless coverable under a different Maryland Medicaid Program that is not specifically addressed in this manual (i.e. hospital services, home health services, etc.). Please refer to the departmental listing of Medicaid Programs on page 3 of these guidelines for possible coverage of therapy services under a different Maryland Medicaid Program.

Under 21 years of age –EPSDT Population

Speech language pathology, occupational therapy and physical therapy services provided to recipients who are 20 years of age or younger are part of Maryland Medicaid's fee-for-service system when not provided as a home health or inpatient service. Home health and inpatient care are coverable by the MCO. Therapy providers who are enrolled as a Maryland Medicaid provider may render the prescribed therapy services and bill the Program directly on the CMS-1500 form under his/her Maryland Medicaid assigned provider identification number.

Chiropractic services continue as a covered benefit under the MCO system; these services must be billed to the MCO for MCO enrollees. Contact the MCO for preauthorization/treatment procedures for chiropractic services.

(Medicaid Provider Types 13, 16,17,18 and 28)

BILLING GUIDELINES FOR THERAPY/CHIROPRACTIC SERVICES

The following billing instructions are to be used for fee-for-service therapy/chiropractic services provided by the provider types addressed in this manual. Occupational therapy, speech therapy and chiropractic services are limited to children under Medicaid's EPSDT Program ***(under the age of 21).*** Physical therapy services are covered for all age groups; however, MCO enrollees who are 21 or older are covered through the MCO and are not considered fee-for-service. In addition, EPSDT chiropractic services are covered through the MCO for MCO enrollees.

The providers addressed in these guidelines cannot bill the Program using a ***physician's*** provider number. They are ***not*** considered physician extenders. They must enroll with the Program and be assigned their own provider number. All fee-for-service claims are to be billed under the assigned Medicaid provider number for therapy services.

Fee For Service(FFS) Billing

Providers shall bill the Maryland Medicaid Program for reimbursement on the CMS-1500 and attach any requested documentation. Maryland Medicaid specific procedure codes are required for billing purposes. Providers are paid based on the Physician's fee schedule.

The Program reserves the right to return to the provider, before payment, all invoices not properly signed, completed and accompanied by properly completed forms required by the Department.

The provider shall charge the Program their usual and customary charge to the general public for similar services. The Program will pay for covered services, the lower of:

- the provider's customary charge to the general public
- the Department's fee schedule

The Provider may not bill the Program for:

- services rendered by mail or telephone
- completion of forms and reports
- broken or missed appointments
- services which are provided at no charge to the general public

To ensure payment by the Maryland Medicaid Program, ***Always*** check Maryland Medicaid's Eligibility Verification System (EVS) for ***every Medicaid patient*** on the date of service.

Under Medicaid's fee-for-service system, services are reimbursed on a per visit basis under the procedure code that is listed on Maryland Medicaid's established procedure code.

Effective July 1, 2009 providers are paid based on the physician's fee schedule. The schedule will indicate the maximum units allowed for the service and the fee amount for each unit of service. The maximum units are the total number of units that can be billed on the same day of service. Maryland Medicaid will reject claims that exceed the maximum units of service allowed amount.

(Medicaid Provider Types 13, 16,17,18 and 28)

PLEASE NOTE: Providers who are assigned a "rendering" provider number cannot bill the Medicaid Program without a group provider number and vise a versa. At this time, therapy group [type 28] providers can bill without a rendering provider number on the claim. Contact Medicaid's Provider Relations Office if you need assistance in completing the claim.

MCO Billing

Claims for recipients who are 21 years of age or older and enrolled in an MCO, must be forwarded to the MCO for payment. Contact the MCO for information regarding their billing and preauthorization procedures.

Chiropractic services are a covered benefit through the MCO system for recipients who are 20 years old and younger. Contact the MCO for information regarding their billing and preauthorization procedures.

Regulations

Visit the following website to review the regulations that pertain to this manual:

www.dsd.state.md.us/comar

Select option #3; choose select by title number; select title number 10-Department of Health and Mental Hygiene; Select Subtitle 09-Medical Care Programs; Select regulations 10.09.37 - EPSDT: Referred Services and 10.09.17 - Physical Therapy Services

The Health Insurance Portability and Accountability Act of 1996 (HIPPA)

HIPPA is the Health Insurance Portability and Accountability Act, a Federal law enacted on August 21, 1996. HIPPA's purpose is to improve the efficiency and effectiveness of the health care system by standardizing the electronic exchange of administrative and financial data, provide security requirements for transmitted information, and to protect the privacy of identifiable health information.

For more information on HIPPA, contact:

www.dhmh.state.md.us/hipaa **www.wedi.org** www.cms.hhs.gov/hipaa/

Medicare

The Program will authorize payment on Medicare claims if:

- The provider accepts Medicare assignments;
- Medicare makes direct payment to the provider;
- Medicare has determined that services were medically justified;
- The services are covered by the Program; and
- Initial billing is made directly to Medicare according to Medicare guidelines

(Medicaid Provider Types 13, 16,17,18 and 28)

Recovery and Reimbursement

If the recipient has insurance or other coverage, or if any other person is obligated, either legally or contractually, to pay for, or to reimburse the recipient for the services in these guidelines, the provider should seek payment from that source first. If an insurance carrier rejects the claim or pays less than the amount allowed by the Medicaid Program, the provider should submit a claim to the Program. A copy of the insurance carrier's notice or remittance advice should be kept on file and available upon request by the Program. In this instance, the CMS 1500 must reflect the letter K [services not covered] in box 11 of the claim form. Contact Medicaid's Provider Relations Office if you have questions about completing the claim.

Medical Assistance Payments

You must accept payment from Medical Assistance as ***payment in full*** for a covered service.

You ***cannot*** bill a Medical Assistance recipient under the following circumstances:

- for a covered service for which you have billed Medical Assistance;
- when you bill Medical Assistance for a covered service and Medical Assistance denies your claims because of billing errors you made, such as:
  - wrong procedure codes,
  - lack of preauthorization,
  - invalid consent forms,
  - unattached necessary documentation,
  - incorrectly completed form,
  - filing after the time limitations, or
  - other provider errors;
- when Medical Assistance denies your claim because Medicare or another third party has paid up to or exceeded what Medical Assistance would have paid;
- for the difference in your charges and the amount Medical Assistance has paid;
- for transferring the recipient's medical records to another health care provider;
- when services were determined to not be medically necessary. The recipient must be notified and the Eligibility Verification System (EVS) verified.

You ***can*** bill the recipient under the following circumstances:

- if the service provided is not covered by Medical Assistance and you have notified the recipient prior to providing the service that the service is not covered; or
- if the recipient is not eligible for Medical Assistance on the date you provided the service.

(Medicaid Provider Types 13, 16,17,18 and 28)

Fraud and Abuse

It is illegal to submit reimbursement requests for:

- amounts greater than your usual and customary charge for the service. If you have more than one charge for a service, the amount billed to the Maryland Medical Assistance Program should be the lowest amount billed to any person, insurer, health alliance or other payer;
- services which are either not provided or not provided in the manner described on the request for reimbursement. In other words, you must accurately describe the service performed, correctly define the time and place where the service was provided and identify the professional status of the person providing the service;
- any procedures other than the ones you actually provide
- multiple, individually described or coded procedures if there is a comprehensive procedure which could be used to describe the group of service provided;
- unnecessary, inappropriate, non-covered or harmful services, whether or not you actually provided the service;
- services for which you have received full payment by another insurer or party.

You are required to refund all overpayments received from the Medical Assistance Program within 30 days. Providers must not rely on Department requests for any repayment of such overpayments. Retention of any overpayments is also illegal.

Sanctions – Against Providers – General

If the Program determines that a provider, any agent or employee of the provider or any person with an ownership interest in the provider or related party of the provider has failed to comply with applicable Federal or State laws or regulations, the Program may initiate one or more of the following actions against the responsible party:

- suspension from the Program;
- withholding of payment by the Program;
- removal from the Program;
- disqualification from future participation in the Program either as a provider or as a person providing services for which Program payment will be claimed; and

- referral to the Medicaid Fraud Control Unit for investigation and possible prosecution.

(Medicaid Provider Types 13, 16,17,18 and 28)

Sanctions – Against Providers – General(continued)

The Medical Assistance Program will give reasonable written notice of its intention to impose any of the previously noted sanctions against a provider. The notice will state the effective date and the reasons for the action and will advise the provider of any right to appeal.

If the U.S. Department of Health and Human Services suspends or removes a provider from Medicare enrollment, the Medical Assistance Program will take similar action against the provider.

A provider who is suspended or removed from the Medical Assistance Program or who voluntarily withdraws from the Program must inform recipients ***before*** rendering services that he/she is no longer a Medical Assistance provider and the recipient is therefore financially responsible for the services.

Sanctions Against Providers – Specific

In addition to penalties arising from any criminal prosecution, which may be brought against a provider, Medical Assistance may impose administrative sanctions on a provider should the provider defraud or abuse the Program.

Administrative sanctions include termination from the Medical Assistance Program, suspension from the Program or required participation in provider education. Examples of instances in which Medical Assistance may take administrative action are when a provider:

- Refuses to allow authorized auditors or investigators reasonably immediate access to records substantiating the provider's Medical Assistance billings;
- Is not in compliance with the following:
  - Maryland Statutes;
  - Federal and State rules and regulations;
  - Medical Assistance policy handbooks;
  - The Medical Assistance provider agreement;
  - Maryland Administrative Code;
  - in excess of recipient's needs;
  - harmful to the recipient; or,
  - insufficient to meet the recipient's needs
- Fails to provide necessary access to medical care for recipients who are bound to the provider through MCOs or HMOs or "lock-in" programs, including

- not providing necessary preventive care and treatment in a reasonably timely manner,

- failing to provide reasonable accessible and adequate 24-hour coverage for evaluation of emergency complaints,

(Medicaid Provider Types 13, 16,17,18 and 28)

Sanctions Against Providers – Specific (continued)

- discouraging a recipient from seeking medically necessary care,

- failing to provide a timely referral to an accessible provider for medically necessary care and/or ancillary services, or

- making a misleading statement of a material fact as to the recipient's medical condition or need for referred or emergency care, whether to the Program or to another provider;

- provides misleading or false information to the Medical Assistance Program, or to its authorized representatives or delegates;
- demands, bills or accepts payments from recipients or others for services covered by Medical Assistance;
- has been indicted for, convicted of, or pled guilty to Program related offenses, or is suspended or terminated from the Medicare Program; or,
- does not have all required professional licensure and certifications necessary for the services he/she is performing.

Appeal Procedure

Appeals that are authorized by Medical Assistance regulations are conducted under the authorization of COMAR 10.09.36.09 and in accordance with COMAR 10.01.03 and 28.02.01. To initiate an appeal, the appeal must be filed within 30 days of receipt of a notice of administrative decisions in accordance with COMAR 10.01.03.06.

(Medicaid Provider Types 13, 16,17,18 and 28)

MARYLAND MEDICAL ASSISTANCE PROGRM
PROCEDURE CODE AND FEE SCHEDULE
EPSDT OT, SP, AND CHIROPRACTIC SERVICES
PT SERVICES
July, 2010

Please Note: Services are reimbursed up to the maximum units as indicated on this schedule. Providers enrolled as a Therapy Group (type 28) may bill a per visit charge for each *enrolled* discipline participating in the group. Please refer to the Physician fee schedule for maximum reimbursement.

		Maximum Units
EPSDT SPEECH LANGUAGE PATHOLOGY		
92506	Initial Evaluation	1
92507	Individual	1
92508	Group	1
EPSDT OCCUPATIONAL THERAPY		
97003	Occupational Therapy Evaluation	1
97530	Therapeutic Activities, each 15 minutes	4
PHYSICAL THERAPY		
97001	Physical Therapy Evaluation	1
97110	Therapeutic Procedure, each 15 minutes	4
97139	Unlisted Therapeutic Procedure (Specify)	1
97140	Manual Therapy Techniques, each 15 minutes	4
95860	Electromyography: one extremity and related paraspinal areas	1
95861	Electromyography: two extremities and related paraspinal areas	1
95863	Electromyography: three extremities and related paraspinal areas	1
95864	Electromyography: four extremities and related paraspinal areas muscles; unilateral	1
95868	Electromyography: cranial nerve supplied muscles; bilateral	1
95869	Electromyography: limited study of specific muscles (for example, thoracic spinal muscles)	1
95900	Nerve conduction, velocity or latency study, or both; motor each nerve	1
95904	Nerve conduction, velocity or latency study, or both sensory, each nerve	1
EPSDT CHIROPRACTIC SERVICES		
98940	Chiropractic Manipulative Trtmnt, Spinal, 1 to 2 regions	1
98941	Chiropractic Manipulative Trtmnt, Spinal, 3 to 4 regions	1
98942	Chiropractic Manipulative Trtmnt, Spinal 5 regions	1
98943	Chiropractic Manipulative Trtmnt, Extraspinal, 1 or more regions	1

Claims must reflect the above referenced procedure codes for proper reimbursement. These codes are specific to services outlined in the Provider Manual for EPSDT Chiropractic, Speech and Occupational Therapies as well as Physical Therapy Services and are specific to the MD Medicaid fee-for-service system of payment. Providers must bill Medical Assistance their usual and customary fees charged to other patients.

*Individual Consideration – code 97139 will be evaluated by a Program Consultant. The consultant will review both the scope of the service provided and the complexity of that service. Reimbursement will then be made by the Program, based on the reimbursement provided for the services of similar scope and complexity.

MARYLAND MEDICAL ASSISTANCE PROGRAM
MOST FREQUENTLY REQUESTED TELEPHONE NUMBERS

CHILDREN'S HEALTH PROGRAM (CHPs)	(800) 456-8900
ELIGIBILITY VERIFICATION SYSTEM (EVS)	
Metro Baltimore	(410) 333-3020
Outside Metro Baltimore	(800) 492-2134
GENERAL PROVIDER RELATIONS	
Claims Resolution (Billing Questions, Payment Issues)	(410) 767-5503 or (800) 445-1159
Tape Billing - technical problems	(410) 767-5977
Third-Party Liability (other insurance)	(410) 767-1765
Missing Payment Voucher/Lost or Stolen Check	(410) 767-5344
Recoveries	(410) 767-1783
Medicaid Liaison Unit	(410) 767-5445
HEALTHCHOICE (Managed Care Organizations)	
Key Facts, Benefits and Services	(410) 767-1482
Enrollment Broker	(800) 977-7388
Provider Hotline	(800) 766-8692
Recipient Hotline	(800) 284-4510
General Questions	(800) 492-5231
PUBLIC MENTAL HEALTH SYSTEM	1-800-888-1965
CASE MANAGEMENT [REM]	1-800-565-8190
MEDICAID POLICY/COVERAGE ISSUES	
Audiology Services	(410)767-1722
School Based Health Centers	(410) 767-1903
IEP/IFSP SERVICES	(410) 767-1903
DENTAL SERVICES	(410) 767-5706
DME/DMS	(410) 767-1476
Preauthorization-disposables	(410) 767-1739
Preauthorization-durable medical	(410) 767-1739
Preauthorization: Audiology and Vision	(410) 767-1722
Preauthorization-Private Duty Nursing	(410) 767-1712
Healthy Kids/EPSDT Program	(410) 767-1683
Healthy Start/Family Planning	(410) 767-6750
Laboratory	(410) 767-5706
Model Waiver	(410) 767-5220
Physicians/Nurse Practitioners	(410) 767-1722
Autism Waiver	(410) 767-5220
PREGNANT WOMEN AND CHILDREN'S INFORMATION	
HOTLINE	(800) 456-8900
PROVIDER MASTER FILE (ENROLLMENT) (Application, Address Changes)	(410) 767-5340
PROVIDER RELATIONS (claim issues, adjustments, training etc.)	1-800-492-5908

Contact 410-767-1482 for the current MCOs associated with Maryland Medicaid.

LICENSING BOARD CONTACTS

Speech Language Pathology

Board of AUD/HAD/SLP
Department of Health and Mental Hygiene
4201 Patterson Avenue
Baltimore, Maryland 21215
Phone: 410-764-4725
Fax: 410-358-0273
e-mail: cosbyz@dhmh.state.md.us

Occupational Therapy

Contact Information: mdotboard@dhmh.state.md.us

Telephone
410-402-8560
FAX
410-402-8561
Postal address
Spring Grove Hospital, Benjamin Rush Building, 55 Wade Avenue, Baltimore, MD 21228

Physical Therapy

Board of Physical Therapy Examiners
4201 Patterson Avenue
Baltimore, MD 21215-2299
(E-Mail) tyminska@dhmh.state.md.us(E-Mail)

(410) 764-4752 (Telephone)
(410) 358-1183 (Fax)
(800) 542-4964 (TDD)
(800) 735-2258 (Maryland Relay Service)

Chiropractic Examiners

James J. Vallone, *Administrator* (410) 764-4726
e-mail: vallonej@dhmh.state.md.us
web: www.mdchiro.org

Mailing Address: Board of Chiropractic Examiners
4201 Patterson Ave.,
Balto., MD 21215-2299

1-877-463-3464 (toll free)
fax: (410) 358-1879

Maryland Medical Assistance Program
Therapy Services Plan of Care for Children
Quarterly Progress Report for Period ___/___/___ through ___/___/___

Patient Information:

Child's Name: _____ DOB: ___/___/___ MA# _____
Child's MCO: _____ Child's PCP: _____ PCP telephone #: _____

Service Information:

Service Type:
___ Speech Pathology ___Occupational Therapy ___Physical Therapy ___Audiology
(If multiple services are provided, list different treatment goals/progress summary by each type of service.)

Sessions Scheduled: _____ Sessions Attended: _____
IFSP: Yes_____ No _____ IEP: Yes _____ No _____

Therapy Provider Information:

Provider Name: _____ Provider telephone #: _____

Address: _____ Provider fax #: _____

_____

Specific Treatment Goals and Progress Summary:

Goal	Performance Objective	Progress Summary

Therapy Provider's Recommendations:

Check one:

____ Plan of care completed - no additional services needed.
____ Home care instructions given to family [____/____/____].
DATE
____ It is recommended that _____ services be continued _____ for _____ minute
(ST/OT/PT/audiology) (Freq.e.g.1x/week) (Intensity, e.g.30)
sessions for _____.
(Duration, e.g. 3 months)

Therapist's Signature: _____ License# _____ Expiration Date_____

Child's PCP Comments: (optional)

Billing Instructions: For dates of service on or after November 1, 1999, Maryland Medical Assistance is financially responsible for speech pathology, occupational therapy, physical therapy and audiology (including hearing aids) services for children under age 21 who are enrolled in HealthChoice. These therapy services should be billed directly to Maryland Medical Assistance via your Maryland Medicaid authorized provider number. All other related services (i.e., disposable medical supplies, durable medical equipment) for children receiving therapy services must be authorized by HealthChoice MCOs.